DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
LONG TERM SUPPORTS EXPANSION REQUEST

General Instructions

Submit the completed application to **Email:** DIDDProvider.Application@tn.gov

All questions and correspondence regarding the expansion request should be directed to: **Email:** DIDDProvider.Application@tn.gov **or Phone:** (615) 532-6530

Please provide the following information:

Date of Request to Expand: _____

_____
Name of Organization

_____
Address

_____
City State Zip Code

_____ _____ _____
Telephone Number Fax Number E-Mail Address

1. **Check the service(s) being requested and identify the region(s) the organization proposes to expand service (s) :**

REQUESTED WAIVER SERVICE (S)	REQUESTED REGION(S)		
	WEST	MIDDLE	EAST
***Support Coordination			
Community-Based Day			
In-Home Day			
Supported Employment Day			
Behavior Respite			
Respite			
*** Intensive Behavioral Residential Services (IBRS)			
Family Model Residential Support			
Medical Residential Services			
Personal Assistance			
Residential Habilitation			
Semi Independent Living (Self Determination waiver only)			
Supported Living			
Individual Transportation for Personal Assistance and/or Respite			
Personal Emergency Response Systems			

Date of Request to Expand:

Name of Organization

***Support Coordination / Transitional Case Management providers may expand to other regions, but are prohibited from providing other waiver services.

*** Intensive Behavioral Residential Services (IBRS): If the provider is only requesting to add the IBRS waiver service, address only number 5 below and complete and submit your response to the IBRS Provider Application Response Requirements.

*****For all other requested waiver service(s) in the above table, answer numbers 2- 5**

2. Revised agency supervision plan.
3. Revised organizational chart.
4. Job descriptions for new service(s).
5. Home and Community-Based Services (HCBS) Settings Rule: Date Provider last completed the TN Residential Provider Self-Assessment or the Non-Residential Provider Self-Assessment. If your agency has not submitted an assessment, please complete the appropriate assessment and submit with this application. _____

Printed Name of Authorized Representative

Signature

Title

Date

For DIDD

- ☐ QA survey report reviewed. _____
  Reviewed: _____
  Query of complaints
  Reviewed: _____
- ☐ Query of investigations
  Reviewed: _____
- ☐ Regional Office recommendations: _____
  Central Office recommendations: _____
- ☐ TennCare Approval: _____